STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030471

[redacted]

Dear [redacted],

On May 18, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 21, 2018 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030471

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly determine that you, your spouse, and your daughter were ineligible for advanced payment of the premium tax credits and cost-sharing reductions?
>
> Did NY State of Health properly determine that you, your spouse, and your daughter were ineligible for the Essential Plan?
>
> Did NY State of Health properly determine that your youngest child was eligible for a full-pay Child Health Plus plan?
>
> Did NY State of Health properly determine that you, your spouse, your daughter, and your youngest child were ineligible for Medicaid?

Procedural History

On March 20, 2018, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared stating, in part, that you, your spouse and your daughter were eligible to purchase a qualified health plan at full cost through NYSOH and that your youngest child was eligible for a full-pay Child Health Plus plan.

Also on March 20, 2018, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you, your

spouse, your daughter, and your youngest child were not eligible for an increased amount of financial assistance.

On March 21, 2018, NYSOH issued an eligibility determination notice stating that you, your spouse, and your daughter were eligible to purchase a qualified health plan at full cost through NYSOH, effective April 1, 2018, and that your youngest child was eligible for a full-pay Child Health Plus plan, effective May 1, 2018. That notice also stated that you, your spouse, your daughter were ineligible for advanced payment of the tax credit (APTC), cost-sharing reductions, or the Essential Plan and you, your spouse, your daughter, and your youngest child were not eligible for Medicaid because your annual household income was over the allowable income limits for those programs.

On May 18, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was held open until June 4, 2018, to allow you time to submit supporting documents.

On May 18, 2018, you uploaded one document to your NYSOH account, which contained the supporting documentation. The document was incorporated into the record as "Appellant's [redacted]" and the record was closed early since the documentation provided was the supporting documentation requested by the Hearing Officer.

Findings of Fact

A review of the record supports the following findings of fact:

1) You testified that you expect to file your tax return for 2018 with a tax filing status of married filing jointly. You will claim two dependents on that tax return.

2) You are seeking health insurance for yourself, your spouse, your daughter, and your youngest child.

3) At all times relevant, your daughter was [redacted] and your youngest child was [redacted]

4) The application that was submitted on March 20, 2018 listed an annual household income of $134.000.00, consisting of income you received from your employment. You testified that this amount was correct.

5) You testified, and provided documentation to show, that you were terminated from your employment on [redacted].

6) You testfied, and provided documentation to show, that you were receiving severance pay twice a month until January 19, 2018.

7) You testified, and provided documentation to show, that you were given a lump sum in the amount of $109,310.09 on February 15, 2018.

8) You testfied, and provided documentation that confirmed, you are not eligible to apply for unemployment benefits until July 8, 2018.

9) You testfied that you received no income for the month of March 2018.

10) You testfied that you are currently receiving no income.

11) You testfied that you are currently seeking new employment, but as of the date of the hearing, you were not employed.

12) You testfied that your spouse does not receive any income and is unemployed.

13) Your application states that you and your spouse will not be taking any deductions on your 2018 tax return.

14) Your application states that your family lives in [redacted], NY.

15) You testified that you have bills including your mortgage, and other monthly bills that you think should be taken into consideration when determining your household income.

16) You testfied that you are unable to afford to pay for your and your family's health insurance without financial assistance due to the fact that you are unemployed.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45

CFR § 155.305(f), 26 CFR § 1.36B-2, 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Federal Register 8831).

Cost-Sharing Reductions

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable FPL or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at

or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance"; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

In an analysis of Child Health Plus eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2018 FPL, which is $25,100.00 for a four-person household (83 Fed. Reg. 2642).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2018 FPL, which is $25,100.00 for a four-person household (83 Fed. Reg. 2642).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified

adjusted gross income*"* means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id*.).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you, your spouse, and your daughter were ineligible for APTC and cost-sharing reductions.

The application that was submitted on March 20, 2018, listed an annual household income of $134,000.00 and the eligibility determination relied upon that information.

During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, which include mortgage, electricity, and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as mortgage and other monthly bills to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be $134,000.00.

You, your spouse, and your daughter are in a four-person household for purposes of this analysis. This is because you expect to file your 2018 income tax return as married filing jointly and will claim two children as dependents on that tax return.

An annual income of $134,000.00 is 544.72% of the 2017 FPL for a four-person household. APTC are generally available to an applicant who expects to have a household income between 138% and 400% of the applicable FPL. At 544.72% of the FPL, you, your spouse, and your daughter are not eligible for APTC.

Therefore, NYSOH correctly determined that you, your spouse, and your daughter were ineligible for APTC and eligible to enroll in a qualified health plan at full cost, based on the information you provided.

Further, since cost-sharing reductions are only available to applicants who qualify for APTC, NYSOH properly determined that you, your spouse, and your daughter were ineligible for cost-sharing reductions.

The second issue under review is whether NYSOH properly determined that you, your spouse, and your daughter were not eligible for the Essential Plan.

The Essential Plan is generally provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $24.600.00 for a four-person household. Since an annual household income of $134,000.00 is 544.72% of the 2017 FPL, NYSOH correctly determined that you, your spouse, and your daughter were ineligible for the Essential Plan.

The third issue under review is whether NYSOH properly determined that your youngest child was eligible to enroll in a full-pay Child Health Plus plan.

According to your NYSOH account, your youngest child is in a four-person household because you expect to file your 2018 federal tax return as married filing jointly and will claim your two children as dependents.

In the March 20, 2018 application, you attested to an expected annual household income of $134,000.00. The application stated that your youngest child is [redacted]. NYSOH relied upon this information when determining your youngest child's eligibility.

A child is eligible to enroll in Child Health Plus with a premium subsidy if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income over 400% are responsible for the full premium cost associated with the Child Health Plus plan. On the date of your application, the relevant FPL was $25,100.00 for a four-person household. Since $134,000.00 is 533.86% of the 2018 FPL, NYSOH properly determined that your youngest child was eligible for a full-pay Child Health Plus plan.

The final issue under review is whether NYSOH properly determined that you, your spouse, your daughter, and your youngest child were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable

family size. Further, Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 154% of the FPL for the applicable family size.

There is no indication in the record that you, your spouse, your daughter, or your youngest child would be ineligible due to non-financial requirements.

On the date of your application, the relevant FPL was $25,100.00 for a four-person household. Since $134,000.00 is 533.86% of the 2018 FPL, NYSOH properly found you, your spouse, your daughter, and your youngest child to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid, you, your spouse, and your daughter would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,887.00 per month, and your youngest child would need to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is $3,222.00 per month.

You testified, and provided documentation to show, that you were terminated from your employment on [redacted]. You further testified, and provided documentation to show, that you received semi-monthly severance payments until January 19, 2018. You also testified, and provided documentation to show, that you received one final lump sum severance payment on February 15, 2018. You testfied, and the documentation you submitted confirms, that you are ineligible for unemployment benefits until after July 8, 2018. As a result, you testfied that you had no monthly income for the month of March 2018. You further testfied, and your application indicates, that you spouse receives no income and did not receive any income in the month of March 2018. As a result, your household's monthly income for the month of March 2018 was $0.00. The record further indicates that your household's current monthly income is also $0.00.

Since the March 21, 2018 is no longer supported by the record such that your, your spouse, your daughter, and your youngest child's eligibility for financial assistance will need to be redetermined.

Therefore, your case is RETURNED to NYSOH to redetermine your, your spouse, and your two youngest children's eligibility, as of the date of this Decision, based on a four-person household, for a family residing in Nassau County, NY with an expected monthly income for May 2018 of $0.00, and to notify you accordingly.

Decision

The March 21, 2018 is no longer supported by the record such that your, your spouse, your daughter, and your youngest child's eligibility for financial assistance will need to be redetermined.

Your case is RETURNED to NYSOH to redetermine your, your spouse, and your two youngest children's eligibility, as of the date of this Decision, based on a four-person household, for a family residing in [redacted], NY with an expected monthly income for May 2018 of $0.00, and to notify you accordingly.

Effective Date of this Decision: May 24, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your, your spouse, or your two youngest children's eligibility.

Your case is being sent back to NYSOH to redetermine your, your spouse and your youngest children's eligibility for financial assistance based on the information presented during the hearing. NYSOH will notify you once this has been completed.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The March 21, 2018 is no longer supported by the record such that your, your spouse, your daughter, and your youngest child's eligibility for financial assistance will need to be redetermined.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Your case is RETURNED to NYSOH to redetermine your, your spouse, and your two youngest children's eligibility, as of the date of this Decision, based on a four-person household, for a family residing in [redacted], NY with an expected monthly income for May 2018 of $0.00, and to notify you accordingly.

This is not a final determination of your, your spouse, or your two youngest children's eligibility.

Your case is being sent back to NYSOH to redetermine your, your spouse and your youngest children's eligibility for financial assistance based on the information presented during the hearing. NYSOH will notify you once this has been completed.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).